Annex 1

Advertised Call for Submission No.2148

Delivery of Mental Health Community Support Services in Victoria

Service Specification for the Delivery of Mental Health Community Support Services

Contents

Introduction

This Service Specification provides information to assist Prospective Service Providers to prepare a submission/s for the delivery of the following Mental Health Community Support Services (MHCSS):

- Catchment-based community intake assessment function
- Individualised client support packages
- Youth Residential Rehabilitation Services
- Catchment-based planning function.

Information is provided on the objectives, funding model and unit price, and key features for each service and function. Please note this document is not intended as an exhaustive service guideline.

Information is also provided on the Information Management/Information Communication Technology domains Prospective Service Providers should take account of when preparing this aspect of their submission.

This document forms part of the Advertised Call for Submission. The Department of Health (the Department) reserves the right to modify any aspect of this service specification.

Statement of Principles

The following principles will guide and inform the way high quality MHCSS are planned and delivered for people with a severe mental illness and psychiatric disability in Victoria:

- **Achieving best outcomes for clients -** The overriding goal of organisations which implement government funded programs and services is to ensure that service delivery improves outcomes and quality of life of the people who use them, maximising individual and public value.
- **Rights and responsibilities** – organisations respect and uphold the rights and responsibilities of clients, carers and staff. Clients have the right and responsibility to make decisions regarding their lives and the support they need.
- **Client-centred and directed -** organisations will provide support that places the client at the centre and encourages and empowers them as decision makers in their own support, respecting and effectively responding to their individual choices, needs, values and preferences. Client-centred support engages the client, and their carers and families (including dependent children), as key contributors to their recovery.
- **Choice** - clients will have a choice regarding who provides their support. The new service delivery arrangements will maintain diversity within a catchment and across the state, offering clients genuine options that meet their needs and preferences.
- **Consumer and carer participation** – organisations actively facilitate client and carer participation at the individual and organisational levels in order to improve safety and quality outcomes.
- **Priority access** – organisations will prioritise access to people who are most disabled by their mental health condition.
- **Accessible and responsive -** organisations demonstrate the capacity to provide support in a way that addresses barriers to access and is responsive to the needs of individual clients, and in particular, clients who are disadvantaged or have complex needs. Support provided (type, intensity and duration) will be determined according to client need and aspirations.

- **Responsive to local need -** services should be delivered which are responsive to the distinctive needs of the community in which they are being delivered and tailored to the particular circumstances faced by communities of interest, particularly population cohorts known to face significant or multiple disadvantage.
- **Recovery oriented** – organisations demonstrate a recovery oriented holistic approach in service delivery, culture and practice which supports the client and builds their capacity to self-manage their mental illness and cope with life stressors.
- **Family inclusive** - organisations demonstrate a family inclusive approach in service delivery, culture and practice which support the sustainable recovery of clients and carers and family. This includes a focus on the safety and wellbeing of dependent children.
- **Effective** - organisations demonstrate a commitment to the provision of support that leads to improved outcomes for clients, including by providing support that is evidence-based and delivered with relevant skills, knowledge and capability.
- **Safe** - organisations minimise the risk of harm to clients, carers, their families (including dependent children) staff and visitors.
- **Organised for quality** - organisations are committed to continuous improvement across all aspects of service provision.
- **Driven by information -** organisations are committed to ensuring support provided to clients is based on up-to-date information, knowledge and evidence. Information is consistently used to drive improvements in the delivery of support.
- **Skilled competent workforce** - organisations are committed to ensuring the workforce has the skills, relevant competencies (including dual diagnosis and dual disability capability), culture and attitude to provide high quality client directed services.
- **Service continuity and partnership** - organisations will strategically partner with a range of local mental health, primary healthcare, human services and other relevant community services in the catchment to generate a common purpose, address barriers to access and deliver a 'joined up' response to the needs of clients.
- **Public accountability** – public accountability should focus on outcome performance rather than simply complying with process with a particular emphasis on the effective use of funding received to achieve agreed outcomes for service users and on measuring the longer term social impact of programs and services.

Clients have the right to privacy and should provide informed consent for any information regarding their care to be exchanged between workers within a MHCSS or with other agencies. There is a need to balance the client's right to privacy with the needs of significant others involved in the person's informal day to day support for information essential to this role. Services providers must have clear policies and processes regarding this that are consistent with *Victorian Information Privacy Act* and associated Information Privacy Principles.

Target client group

People eligible to receive MHCSS will:

- be 16-64 years of age
- have a disability that is attributable to a psychiatric condition and
- have impairment or impairments that are permanent, or are likely to be permanent and
- have an impairment or impairments that results in substantially reduced psychosocial functioning in undertaking one or more of the following activities:
    - communication
    - social interaction
    - learning
    - self-care
    - self-management; and
- have an impairment or impairments that affect their capacity for social and economic participation.

Please note:

- A psychiatric impairment that varies in intensity is also considered permanent if it is likely the person requires ongoing specialist mental health support.
- Priority for core service delivery will be given to people who are most disabled by their psychiatric condition – regardless of diagnosis, capacity for rehabilitation/recovery and living circumstances. Only where there is more than one eligible person with a similar level of disability and need should priority of access be determined on the basis of length of time someone has waited for MHCSS.
- Young people eligible for Youth Residential Rehabilitation (YRR) service may also be less severely disabled than adult MHCSS clients but at significant risk of deterioration of functioning and disruption to development of life skills, relationships, education and employment.
- This eligibility criterion applies to **all MHCSS programs and services**, including Youth Residential Rehabilitation services (Note: Eligible clients for Youth Residential Rehabilitation services will be aged 16-25 years).
- MHCSS will not be extended to new clients aged 65 years and older. Clients who are 65 years or older at the beginning of the new service arrangements in 1 July 2014 however will continue to be eligible for MHCSS and will be offered the choice to continue to receive MHCSS as appropriate or assisted to transition to aged care services or other appropriate community services if preferred.
- The client population should reflect the diversity of the local population and the expected over-representation of disadvantaged groups. Specific target groups will include people with a psychiatric disability with a forensic history and those on Community Based Treatment Orders under the *Mental Health Act 1986*, including those experiencing homelessness, intellectual disability, trauma and/or a co-occurring substance misuse problem.

Clients will likely live in the catchment within which the service operates. However people who live outside the catchment are eligible to receive support in recognition that clients may:

- move out of the area but may wish to remain with their existing service
- want to access a service where their carer/significant other/s live
- have a preference for a particular service provider
- be unable to access their local services for another reason.

Statement of outcomes

Table 1 provides a summary of indicative types of outcomes the Victorian Government is seeking to achieve for people with a severe mental illness and psychiatric disability through the delivery of accessible, efficient, effective and responsive Mental Health Community Support Services. It also illustrates the type of benefits clients should expect as a result of receiving this support, acknowledging that MHCSS providers alone will not be able to achieve all of these outcomes.

Please note this information is illustrative only. The Department reserves the right to amend any *aspect of this statement of outcomes*.

Table 1: Indicative outcomes and benefit to client to which MHCSS is expected to contribute

Outcome domains	**Indicative Outcome**	**Ways benefit to clients might be described**
Effectiveness	Level of psychiatric disability experienced by clients stabilised or improved	- Reduction over time of level of disability experienced by individual clients (as it impacts on their functional ability) linked to a reduction in service intensity - Stabilisation of functional ability for clients with enduring disability - Reduced duration and frequency of Community Treatment Orders under the *Mental Health Act* - Decrease in emotional distress - Improved communication skills
	Clients' capacity for self-management and decision making about their support is improved	- Clients have the skills, knowledge and confidence they need to make informed choices about the type of support they need - Clients articulate personal goals - Clients achieve personal recovery goals
	Improved day-to-day living skills and functional ability	- Clients have improved daily living skills
	Improved symptom stability	- Clients' level of mental health symptoms decreased or stabilised
	Decreased psychiatric crisis, suicide attempts and self-harm	- Clients have plan that identifies strategies for early intervention - Clients are safe from harm
	Improved relationships skills and social connection/reduced social isolation	– Improved quality of personal relationships for clients – Family and carers are positively engaged with person they care for and are part of support system provided to the client – Improved safety and wellbeing of dependent children – Improved quality of personal relationships for clients
		– Client participates in mainstream social and recreational activities that are meaningful to them

Outcome domains	Indicative Outcome	Ways benefit to clients might be described
Effectiveness	Contribution to improved long-term housing security	– Reduction in number of clients experiencing repeated or chronic homelessness
		– Timely access to appropriate and affordable stable housing
		– Maintenance of stable tenancy
	Contribution to improved economic participation	- Engagement by clients in schooling/ vocational training opportunities of their choosing
		- Improved employment participation
	Improved client engagement with health, human services and other key social supports	- Improved engagement with primary health for prevention and/or management of chronic health problems
		- Reduction in preventable illness, key health risks and chronic disease (e.g. obesity, diabetes, smoking)
		- Reduction in harmful behaviour (e.g. substance misuse)
		- Improved engagement with human services and social supports (e.g. housing, welfare services)
	Contribution to decreased engagement with justice system	- Reduction in the number of clients that come into contact with justice system and frequency of contact by individual clients
	Improved involvement of family/carers in support provided to the client	- Family/carers have the skills, knowledge and confidence they need to support the person they care for
		- Active, respectful involvement of carers in decisions related to the provision of support
Efficiency & sustainability	Services are cost efficient	- Services achieve agreed minimum targets consistent with their funding agreement
	Services are cost efficient and accessible	- Services are able to accept new clients on referral within a timely manner
Responsive-ness	Improved responsiveness to population diversity	– Services that are culturally safe – Services effectively engage and respond to diversity – Services effectively engage and respond to individuals/groups known to experience significant disadvantage, particularly: o Aboriginal people, their families and community o People experiencing or at risk of homelessness o People with a dual disability
	Improved involvement of clients in decisions related to their support (i.e. person centered support)	- Client-directed decision making and improved responsiveness to individual clients - Active involvement of carers of clients in decisions related to their support
	Improved responsiveness to carers and family members in their caring role	- Carers/family provided with timely information, referral and advice to support them in their caring role
	Improved responsiveness to dependent children of clients	- Dependent children identified and needs recognised in client's care and support - Dependent vulnerable children referred to appropriate supports - Clients more confident in managing parenting responsibilities

Outcome domains	Indicative Outcome	Ways benefit to clients might be described
Accessibility	MHCSS are easy to find and access	- Referral agencies, clients and carers find it easy to locate MHCSS
	People who are most in need are prioritised for access	- People with high-level psychiatric disability receive priority access and support in a timely manner
	People have reasonable access to MHCSS no matter where they live	- People living in rural Victoria have reasonable access to MHCSS
Continuity	Pathways from clinical mental health treatment to MHCSS are well established and support continuity of care	- Coordination at the service and client level between MHCSS and other mental health services is effective and supports continuity of care for clients - Well established and effective referral pathways exist between MHCSS and mental health treatment services
	Pathways to and from local human services and other social support services are well established and support continuity of care	- MHCSS and human services/social support services collaborate and plan together to achieve improved outcomes for shared clients and continuity of care - Well established and effective referral pathways exist between MHCSS and human services/social support services
Safety	Improved client safety	- Reduction in critical incidents involving clients
	Improved carer/family safety	- Reduction in critical incidents involving carers and family members
	Improved worker safety	- Reduction in critical incidents involving workers

Description of MHCSS services and functions

Catchment-based community intake assessment function

Overview

The catchment-based community intake assessment function will operate in all 15 MHCSS service catchments. It will be managed by a single provider on behalf of all MHCSS provider/s operating in the catchment.

This function will determine and prioritise client eligibility for the Victorian Government funded Mental Health Community Support Services. This includes the following programs:

- Individualised client support packages (which will commence 1July 2014 and will replace all levels of Home Based Outreach Support, Day Programs, Care Coordination, Aged Intensive and Special Client Package funding streams)
- Youth Residential Rehabilitation Services
- Adult Residential Rehabilitation Services[1]
- Supported Accommodation Services.

[1] While Adult Residential Rehabilitation Services and Supported Accommodation Services are out of scope of the 2013-14 recommissioning process, both service types will be required to operate within the new statewide framework.

Service providers of these programs will be required to accept all referrals via this function. This function replaces agency level intake functions from July 2014.

Objectives

The objectives of this function are to:

- make it easier for people with a psychiatric disability, their carers/family and referring agencies to find and access MHCSS
- ensure people who are most disabled by their mental health condition are prioritised for access to MHCSS
- ensure a consistent and transparent approach to the way eligibility is assessed and prioritised across all catchments
- ensure initial assessment takes into account the individual's broader health and social support needs and family circumstances
- offer client's optimal choice MHCSS provider they are referred to
- identify if the person has carer/family support and any referral needs of vulnerable children
- better manage access to bed-based rehabilitation and supported accommodation services at the regional level by coordinating access to these services (including out of area referrals)
- ensure people who may be required to wait for MHCSS - in situations when service demand exceeds supply in a given catchment - are accounted for
- link people to other relevant mental health support services; primary healthcare; specialist clinical mental health; human services and other relevant community services (if required) in a timely manner.

Funding model

The catchment-based community intake assessment function is funded on a block grant basis. Total funding is up to $300,000 per annum per function. This funding is inclusive of all staffing costs (salary and on costs), corporate support costs, and infrastructure support costs.

Key features

At a minimum the catchment-based community intake assessment function has the following key features:

- delivered on a catchment basis
- underpinned by a strong working relationship with key service providers in the catchment. At a minimum, this should include such relationships with Area Mental Health Service/s and MHCSS provider/s operating in the service catchment
- five days a week, 52 weeks a year (excluding weekends and public holidays)
- telephone based and operate Monday to Friday on standard business hours (may use web-based referral processes)
- use of standardised intake assessment criteria, tools and processes to:
  - assess and determine eligibility for MHCSS and priority of need
  - identify initial intensity and type of psychosocial support required
  - identify presenting risk factors relevant to the provision of a safe and appropriate service response

  - provide supported referral (including transfer of relevant information with the individuals consent) to a MHCSS provider/s and local health, human services and other community services as required (based on the initial need identification). Particular emphasis will be placed on cross-referral with relevant local intake points for Commonwealth funded mental health support services (e.g. Partners in Recovery), drug and alcohol treatment, homelessness, disability services and Services Connect (where relevant)

- supports people who require MHCSS but may need to wait for service availability and facilitate active management during this period by providing a structured, evidenced based program to assist people to develop better coping and self-management skills. This function would be delivered in collaboration with MHCSS providers in the catchment.

It should be noted that the intake assessment function does not replace comprehensive assessment that will be undertaken by the MHCSS provider responsible for delivering ongoing support to the client. People who 'walk into' a MHCSS service provider will be supported by the MHCSS service provider to access the community intake assessment function.

Service providers are expected to actively work with community groups/population cohorts in their service catchment to identify people who would benefit from MHCSS, particularly hard to reach groups (such as those experiencing long term homelessness). In this instance, MHCSS providers (as well as other health and community services) should make a supported referral to the community intake assessment function to facilitate the individual's formal intake assessment and subsequent potential access to MHCSS.

Individualised client support packages

Overview

Individualised client support packages aim to minimise long term disability and improve quality of life outcomes by providing clients with the best rehabilitation and recovery support possible, tailored to their individual needs and preferences. Helping people to manage their own mental health better and make decisions related to their support will be a core outcome.

Support packages will be provided:

- 52 weeks a year. The hours of operation should reflect the needs and preferences of clients. Service providers are expected to provide some extended hours coverage.
- on a one-to-one outreach and group basis, based on client need and preference.
- in community settings wherever possible, including the person's place of residence[2]. Support is to be provided to the person regardless of where they live and the nature of their accommodation. This includes private and public housing, rooming and boarding houses, supported residential services, homelessness accommodation, private hotels or caravan parks and people living on the street. *Home* is defined by the client.
- may be provided at an accessible, communal location (subject to client need and preference). This may include structured programs (e.g. focused on building capacity for self management) and social and recreational group activities (e.g. barbecues, film nights, meals out etc.)
- in such a way as to ensure clients receive their direct support through a consistent lead worker, wherever possible, in order to develop a relationship of trust and mutual respect.

[2] This excludes clients living in a bed based rehabilitation service such as Youth and Adult Residential Rehabilitation services, Supported Accommodation Service, Community Care Unit and Secure Extended Care Unit.

Service providers will be required to deliver support using an evidenced-based model of care and ensure all delivery staff are trained and supported to deliver this model. Service providers are also required to deliver individualised client support packages to clients aged 16-25 years within a youth developmental framework (see page 13 for further information).

The provision of an individualised client support package will involve delivering the following individual client related activities, as a minimum:

Client-facing support including:

- comprehensive assessment of client need
- development of a client-directed recovery plan
- monitoring and review of this plan at regular intervals in partnership with the client and their carer/family
- provision of support (based on the client's recovery plan), with a focus on:
    - building the individual's daily living skills and their capacity for self-care and self-management of their mental illness
    - helping the individual to improve their relationship skills and social connectedness
    - supported referral to assist the client to access and engage with health services (e.g. clinical mental health treatment services and primary healthcare, including drug and alcohol treatment services), human services (such as housing) and other social support services they need
    - identifying and appropriately referring children of clients who are vulnerable
    - assisting carers and family, including a brief assessment to identify their needs (including those of dependent children), provision of advice and information, and supported referral to appropriate services, in the context of their caring role
    - activity related to planned discharge, including when a client moves to another MHCSS provider and from a MHCSS bed-based service.

Non-facing client support including:

- liaison, collaboration and coordination with mental health treatment and other relevant health, human services and social support services to facilitate a joined-up response to the person's needs (this includes facilitation of, or participation in, case conferencing with the client and individual advocacy)
- travel time
- time spent documenting case notes or other client related information
- time spent organising activities or providing other support functions on behalf of clients (e.g. organising appointments).

Objectives

The objectives of individualised client support packages are to assist clients to:

- develop the knowledge, skills and confidence they need to make decisions and choices about their support needs
- enhance adaptive coping skills
- learn or relearn skills and develop confidence required for activities of daily living (e.g. budgeting, buying and cooking food, healthy living skills, personal care, care for one's home environment)
- improve the individual's social relationship skills and confidence (e.g. making and keeping social and recreational contacts, and relationships with friends, family, neighbours and significant others)

- access and engage with (public or private) mental health treatment services, including general practitioners as required to manage their mental illness
- contribute to achieving client directed outcomes in regard to physical health, housing, education, training and employment and other relevant needs.

Funding model and unit pricing

Individualised client support packages will be funded on the basis of a standard, single-price unit to be known as a Client Support Unit (CSU). A CSU is based on the average efficient total hourly costs of service delivery. The unit price for a CSU is $76.56. The service provider will be funded an agreed total volume of Client Support Units for the delivery of individualised client support packages.

Activities that can be funded as part of a CSU are described in Part A, Section 3 Funding and Costs of the ACS.

Please note funding cannot be used to subsidise a client's rent.

Key features

Referral to individualised client support packages

Access to an individualised client support package (as well as all other MHCSS programs and functions) by new and returning clients, will be through the community intake assessment mechanism.

Providers funded to deliver individualised client support packages will be required to accept all referrals via this mechanism which will replace intake assessment undertaken at the agency level.

Comprehensive assessment of client need

On referral of clients from the catchment-based intake assessment function, the MHCSS provider will undertake a more **comprehensive needs assessment**, in partnership with the client and their carer and family and other providers (as appropriate), building on the initial findings of the intake assessment.

The comprehensive assessment process may occur over a number of sessions with the client and their carer/s/family (with the client's permission).

At a minimum it will identify the individual's support needs in respect to: capability for self-management; daily living skills; social skills; parenting skills and needs of dependent children; housing needs; carer/family support needs in the context of their caring role; and what the client wants to achieve in respect to physical health (including drug and alcohol problems as relevant), relationships, housing, social connections, education, training and employment and other outcomes as appropriate.

The comprehensive assessment will inform the development of the client's **recovery plan**.

Individual recovery plan development, monitoring and review

The recovery plan will include key outcome domains of:

- mental health self-care and self-management
- daily living skills
- physical health
- housing & living arrangements
- social relationships
- family and carer relationships
- social connections
- education, vocational training and employment
- parenting and carer/family support needs
- needs of vulnerable children.

The recovery plan should be consistent with and support clients to meet requirements under any legal status, particularly community corrections and Compulsory Treatment Orders under the *Mental Health Act 1986*.

Where the client is also a client of the public mental health service system, the recovery plan should be coordinated with the individual's clinical mental health Individual Service Plan to promote improved planning, continuity of care and optimise outcomes for the client. Where a client has a care coordination or integrated plan from another agency, the MHCSS provider should complement this plan.

The recovery plan must be developed in partnership with the client and (where appropriate) their carer(s), family or significant others. The recovery plan should be reviewed on a regular basis with the client to ensure it meets their changing needs and aspirations.

The client must be given a copy of his or her assessment and recovery plan.

Delivery of an individualised client support package

The client's recovery plan will directly inform the type, intensity and duration of support they will receive from the MHCSS provider.

The delivery of the individualised client support package will involve both **client-facing** and **non-facing** client support.

The way support is organised (individual or group basis) will be determined by the individual's preferences. The client will also choose where support is provided. This may likely be in their place of residence (i.e. home-based) although it may also be at other locations selected by the client.

The coordination of care will be an embedded function in delivering an individualised client support package[3].

Other functions that will form part of a client's individualised client support package include:

- structured, evidence-based self-management programs to improve capacity for self management and self-care of their mental illness
- information and advice
- individual advocacy
- supported referral to assist the client to access and engage with local health, human services and social support services
- supported referral of children of clients who are vulnerable
- broader service coordination with mental health treatment and other key services to facilitate a joined-up response to the client's needs (this includes facilitation of, or participation in, case conferencing with the client)
- carer and family support to assist them in their carer role – this includes a brief assessment to identify their needs (including children), advice and information, and supported referral to appropriate services
- activity related to planned discharge, including when a client moves to another MHCSS provider and/or from a bed-based service.

Service providers of bed based MHCSS rehabilitation services are expected to work together to ensure an integrated recovery plan is developed, particularly where the provider of the MHCSS funded bed-based service will not provide ongoing MHCSS after the client leaves the bed-based service.

[3] Where a client requires a coordinated response across numerous services due to high-level disability and their capacity for self-management, MHCSS provider will need to work with agencies delivering the Commonwealth funded Partners in Recovery (PiR) program and/or Services Connect to facilitate access to programs provided by these agencies. In situations where support cannot be provided by PiR, or where in judgment of the MHCSS provider it is in the best interests of the client, the MHCSS should provide care coordination.

The Department has the right to recall funding if service providers do not deliver agreed targets.

Short-term self-management function

The self-management function will enable MHCSS providers to support a larger number of people who may only require short-term support while providing a more structured entry process for those requiring a longer term intervention.

The aim of this function is to support people to develop the skills, capability and confidence they need to better self-manage their mental illness in collaboration with service providers, carers and others.

This function can be delivered on a group basis or individually and should cover areas such as: plans and approaches to cope with daily stressors; skills to identify and manage early warning signs; strategies for responding to an episode of illness; and identifying social supports.

It may also focus on a specific objective that is critical to the client taking the next step in his or her recovery, such as preparing for return to the workforce.

Service providers will be required to offer this function to all new and existing clients as appropriate, using an evidence-based model.

Carer support function

Families and carers can be critical supports for people with a mental illness. They provide important emotional support, as well as practical help and financial assistance. At times, this support can make a significant difference to a person's recovery journey.

Consistent with a family focused approach, carers and family members and significant others of a person who are clients of MHCSS will be eligible for focused support (this includes dependent children). Providers, as part of their core service delivery, will be required to:

- engage carer/s and family members in a timely manner around the needs of the person they are caring for – this will include carer/family engagement in the development and review of a clients' individual recovery plan, with the consent of the client.
- offer the carer/family a brief assessment to identify the presence of a particular problem or need, and as a tool to engage with carers about their caring role.
- provide information and advice regarding their caring role and associated challenges, including information on mental illness, and how to identify early warning signs and provide positive responses in challenging circumstances.
- provide supported referral to a range of relevant community services that can assist with the needs of the carer/family member and support them in their caring role, including consideration of the needs of dependent children in a caring role.

The provision of wider carer support will be considered as part of the review of Victorian Government funded mental health consumer and carer support programs, which includes the Mutual Support and Self Help and Planned Respite programs. These programs are not part of this service specification.

Youth Residential Rehabilitation Services

Overview

The Youth Residential Rehabilitation (YRR) service provides psychosocial rehabilitation support to young people aged 16-25 years with a psychiatric disability in a residential setting. The aim of the YRR service model is to assist the young person to learn or re-learn skills and confidence required for independent living, better manage their mental illness and support them to achieve their recovery goals in respect to social relationships, social connections, recreation, physical health, alcohol and drug issues, education, vocational training and employment and housing and other needs.

The primary focus is on assisting the young person to participate in the local community rather than 'in-house' programs.

Clients of YRR services are referred from a range of sources such as self, carer, general practitioners, clinical mental health services, youth homelessness, youth justice and drug and alcohol treatment services.

This service is not to be used as an alternative for mental health inpatient or sub-acute mental health admission or emergency accommodation.

Youth developmental framework

Service providers are required to deliver YRR services within a youth developmental framework.

A youth developmental framework is the understanding and consideration that young people are developing across many domains. It is a time of biological changes including those affecting neurological development. Adolescence and young adulthood is a stage of life where young people are individuating from families and developing stronger ties with peer groups, developing their own identity and interests, hobbies and skills of their own. Further, this is a period when young people will face particular educational and vocational challenges and milestones such as choosing and embarking on career paths for employment or further study. They are in a period of transition requiring acquisition, realisation and consolidation of particular attitudes, values, and social skills that will enable them to reach adulthood successfully.

In this process of development they are building their social and personal capital, both internal and external (peers, family and community) that will enable them to face challenges and make the most of opportunities that present. To do this they need to develop resilience and also be supported by family, friends and community, along with the institutions/support services they access.

Key developmental milestones to achieve during young adulthood include developing a sense of their own identity, as well as gaining education and/or employment.

The onset of mental health problems in this age group is set against a backdrop of rapidly changing roles and requirements of families and carers as children and young people grow, develop, become increasingly independent and pursue vocational and academic goals.

To practice within a youth development framework is to understand:

- that services are provided in a youth friendly environment
- that symptoms and problems occur within a developmental context
- the importance of the social capital/personal strengths acquisition process
- that working closely with parents and families in developmentally-informed ways promotes recovery and better outcomes across all ages.

- The importance of access to dedicated youth-friendly services collaborating to provide optimal clinical and psychosocial interventions that enable young people to maintain or reconnect with education, employment, pro-social peer groups and community.
- That service responses need to take better account of acuity, severity, complexity, risk and functional impairment as well as diagnosis.
- That concurrent clinical and psychosocial interventions aimed at retaining or establishing engagement in meaningful, age-appropriate activities can significantly improve client outcomes, particularly in relation to social inclusion.
- That young people require a wrap around response which forms a community of support, 'champions' and 'backers', providing and contributing to the environment and experience of the young person.
- That support services need to focus these assets, resources and contributors to nurture and contribute to the young persons' development. The focus in not just on helping the young person to resolve or manage a presenting problem but to also help them prepare for adulthood.

Objectives

The YRR service model (within a youth developmental framework) will support the young person to return to, or progress to, independent living by working with the young person to (as a minimum):

- improve their capacity for self-management of their mental illness and develop the knowledge and confidence they need to make decisions and choices about their support needs
- enhance adaptive coping skills and decrease self-harming behaviour
- learn or relearn skills, and develop confidence, required for activities of daily living
- improve their social and relationships skills and develop/strengthen family and social networks
- develop and consolidate their links with educational, vocational training and employment opportunities
- adopt a healthy lifestyle/harm reduction
- engage with and access clinical treatment and physical healthcare, including alcohol and drug treatment services
- access suitable, stable and affordable housing.

Funding model and unit pricing

The funding model for YRR services is a bed day rate. The standard bed day rate per funded bed is $158 per bed day, although a higher rate ($184 per bed day) may be payable to the Bendigo and Wantirna YRR services if a Prospective Service Provider/s submits proposals that demonstrate they will be better meeting the needs of more complex clients (including clients aged 16-18 years) through models that necessitate 24/7 staff coverage at these sites.

The bed day rate is made on the basis of a specified number of available physical on site beds. The Department will fund a specified maximum number of beds at each YRR service (refer Appendix 2 Description of Catchments and Services by Catchment, Table 1).

The Department will not fund any additional beds beyond the number of beds specified for each facility. While in some instances funding has historically been provided to YRR service providers for non-bed 'outreach' based services, under new arrangements support to young people living in the community will be provided through the individualised client support package component of the MHCSS program.

YRR services are funded on the basis of available bed days. The Department reserves the right to recall funding for vacancies under 90 per cent occupancy over a prolonged period. Target notional hours of support will be calculated and service providers will be required to report actual hours of support delivered to YRR clients to facilitate future evaluation and comparative analysis of cost inputs between facilities.

Physical environment

Youth Residential Rehabilitation services are located in residential areas. Each facility has up to 10 beds. Some facilities consist of 2-3 houses, designed in a manner to provide privacy and autonomy, while others are a large house with a number of bedrooms and shared living areas.

Key features

The YRR service model has the following key features:

- referral via the catchment-based community intake assessment function.
- length of support - up to 12 months. Please note: the length of support will be determined on a case-by-case basis by the young person and the service provider, but will not exceed 12 months unless there are exceptional circumstances.
- on-site support and supervision seven days a week, 52 weeks a year
- client directed recovery plan developed in partnership with the young person and their carer/family (as appropriate) or a plan that forms part of the young person's existing mental health recovery plan.
- provision of direct **client-facing support** (based on the young person's recovery plan), focusing on:
  - building the individual's daily living skills and their resilience and capacity for self-care and self-management of their mental illness (e.g. budgeting, buying and cooking food, healthy living skills, personal care, care for one's home environment).
  - helping the individual to improve their relationship skills and social connectedness (e.g. making and keeping social and recreational contacts, and relating to friends, family, neighbours and significant others).
  - assisting the young person to link and engage with health services (e.g. clinical mental health treatment services and primary healthcare, including drug counselling, sexual abuse counselling), education, vocational training and employment; human services (e.g. housing) and other community services they need.
  - carer and family support to assist them in their carer role (with the young person's consent)[4]. This includes advice and information, and supported referral to appropriate services.
  - activity related to planned discharge, including when a client moves to another MHCSS provider in the service catchment for ongoing support. Service providers are required to provide links to and active follow up during the transition period to support the young person to remain engaged with key services they need to sustain independent living.

[4] There is a need to balance the client's right to privacy with the needs of significant others involved in the person's informal day to day support for information essential to this role.

- **non-client facing support** including collaboration and coordination with health (including clinical mental health, drug and alcohol treatment services and primary healthcare providers), education, vocational, employment and social services (such as housing, youth homelessness and youth justice services) to facilitate a joined-up response to the young person's needs. This includes facilitation of, or participation in, case conferencing with the client and individual advocacy as required and activity related to supporting the young person's successful transition to the community.

Service providers will be required to deliver support using an evidenced-based model of care and practices that are age and developmentally appropriate and trauma informed. The service provider will ensure all delivery staff are trained in provision of this model and are dual diagnosis competent.

Under the reform program, the policy intention is that provision of YRR services will be funded on a non 24 hour support basis, consistent with promoting independence and self management by clients.

YRR services funded at the standard rate ($158 per bed day) should provide on-site support seven days a week with on-call provision overnight. These YRR services are not expected to be staffed on-site on a 24 hour basis. Individual service providers will determine staff rostering/client support arrangements within these parameters.

Tenancy and Accommodation Arrangements

The Department generally provides properties for provision of YRR services by service providers. Arrangements for occupancy of Departmental properties by service providers will be negotiated with Preferred Providers as part of the ACS process.

Current arrangements for the YRR properties are that the Department will be responsible for all maintenance (with the exception of gardens) at all sites excluding the Hawthorn YRR service. In relation to this site, the service provider is responsible for all general maintenance and repairs and the Department is responsible for all major structural maintenance.

Residents of a YRR should have the privacy of their room and the option to choose when they remain or do not remain in the living and personal areas within the facility. For example, residents have the right to remain in the facility without staff supervision. Residents are allowed to invite people into their space, as long as this does not interfere with the rights and privacy of others. Service providers should develop policies to cover the length of stay of any visitors and other related matters.

Fees and charges

The accommodation and maintenance costs of the YRR properties are met by the Department. This means the service provider is not the "landlord" and should not charge clients a fee for occupying a room in the YRR (that is, service providers should not charge clients "rent").

Service providers may charge fees to cover utility and activity/program costs.

Prospective Service Providers should indicate in their submission any fees or charges they propose to charge individual clients of the YRR, provide a rationale for these fees/charges and how they propose to collect and use this funding to benefit the YRR clients and the YRR service more broadly. Any proposed fees or charges must be reasonable.

It is expected clients will pay for their own food to promote independence, consistent with principles of self determination and self responsibility.

Please note any proposed fee or charge should not duplicate any costs covered by funding provided by the Department of Health for YRR services

Catchment-based planning function

Overview

Catchment-based planning function will be undertaken by a single provider on behalf of, and in partnership with other MHCSS operating in the catchment and a range of stakeholders. The Department will allocate a total of $48,000 per catchment for the delivery of this function.

All successful MHCSS service providers in a given catchment will be required to actively participate in the development of the catchment-wide plan as a condition of funding.

Objectives

The objective of the catchment-based planning function is to:

- Gather and analyse relevant health and population data to identify and understand the distinct and diverse needs of adults with a psychiatric disability living in the service catchment, particularly those facing significant disadvantage and discrimination such as those who are homeless or at risk of homelessness, Aboriginal people and people with a dual disability.
- On behalf of, and in collaboration with, other MHCSS providers in the catchment develop and regularly review a common mental health community support plan which will identify current and projected service gaps and pressures and develop cohesive strategies to improve responsiveness to community need and population diversity.
- Engage with relevant agencies and planning structures (for example, Services Connect, Medicare Locals and Local Government through health and well-being plans) and participate in discussions and planning to:
  - identify and develop shared strategies to address systemic barriers to access and deliver a more coordinated response to the needs of people with a psychiatric disability at the system level across the catchment.
  - ensure the needs of people with a psychiatric disability living in the catchment are taken into account in other local planning activity.
- Ensure the views of consumers and carers inform the development and review of the common mental health plan and are represented in other relevant planning forums by creating or engaging in existing catchment level processes and opportunities.

The planner will meet regularly with local Department of Health and other relevant government officials regarding the development, review and implementation of the catchment plan.

Funding model and unit pricing

This function will be funded on a block basis at $48,000 per annum (inclusive of salary, on-costs and corporate support costs). It is expected these funds will be used to employ, on a part time basis, a qualified and experienced planner.

Key features

The planning function has the following key features:

- A single common mental health community support plan developed in collaboration with funded MHCSS providers in the catchment and other key stakeholders, including consumers and carers.
- The plan will be based on analysis of relevant health and population data, supplemented by targeted consultation as required.
- Active involvement with relevant planning structures and processes to influence and jointly plan for the needs of consumers and their carers/family at the catchment level.

Information management and information communication technology systems

Prospective Service Providers are required to describe the information systems that will be used to support the delivery of MHCSS, in addition to their organisational Information Management/Information Communication and Technology (IM/ICT) governance arrangements, policies and practices.

Detailed specification of reporting requirements will be developed over the next 12 months and will continue to evolve, tied to a range of parallel developments including a new National Minimum Data Set for mental health non government organisations and the development of the outcome focused performance management framework for the MHCSS program.

MHCSS providers will need to commit to a continuing process of enhancement but will need a sound IM and ICT capability on which to build.

In responding to the requirements in this ACS, Prospective Service Providers should take account of the IM/ICT domains described in Table 2 and other domains they deem relevant.

Table 2 Information Management and Information and Communication Technology capabilities

Domain	Requirement
Application flexibility	Prospective Service Providers should have an information system/s that are: • Customisable (e.g. can be upgraded with additional functions) • Extensible (e.g. allows for growth in data volumes) • Scalable (e.g. allows for easy deployment at other sites) • Maintainable (e.g. system administrators can update code-sets, add users, create extracts etc.) • Integrated across consortia and partner agencies (where relevant)
Information systems functionality	Prospective Service Providers should have an information system/s that captures the following data domains (as a minimum). • Client details (e.g. name, address etc); Client socio-demographics (e.g. sex, employment status, etc); mental health legal status; Client relationships (e.g. dependents, carer details); Service events (e.g. service start date, contacts, source of funding, etc); Assessment and screening (e.g. diagnosis, comorbidities, etc); Client outcomes (e.g. quality of life) Prospective Service Providers should have information systems that support (as minimum): • Case management functionality including (as a minimum): o Recording individual and group-based service provision o Recording of referrals made to other agencies o Recording client case notes o Scheduling of appointments o Electronic document management (e.g. ability to electronically store and organise scanned documents) and ability to generate, securely send and receive electronic records (e.g. referrals) Health/welfare provider details management o Allocation of clients to waiting lists/wait times • Assessment and screening functionality o Ability to implement standardised tools for intake screening and assessment o Ability to electronically send and receive assessment and screening summaries (e.g. email PDF documents) • Client level outcome measures o Ability to implement standardised tools such as outcome measurement tools and protocols • Business intelligence o Ability to interrogate own data to inform service planning, quality assurance, understanding client experience of care etc • Data export functionality o Ability to create customised data extracts for the purposes of more sophisticated analysis e.g. for evaluation purposes • Resource management o Staffing ◦ Bed availability (if required)
Privacy, security and business continuity	Prospective Service Providers should have implemented business and technology processes to ensure compliance with the *Victorian Health Records Act (2002)* and Victorian Information Privacy Principles. Prospective Service Providers should have an actionable disaster recovery plan in the event of data loss and/or infrastructure failure.
Governance and quality assurance processes	Prospective Service Providers should have clear IM/ICT governance policies, standards and guidelines in accordance with Victorian Government ICT Strategy: 2013-2014.